PRINTED: 05/09/20
FORM APPROVE

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN6801 | A. BUILDING: _____ B. WING _____ | 04/26/2017 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BRIDGE AT SOUTH PITTSBURG, THE | 201 EAST 10TH STREET SOUTH PITTSBURG, TN 37380 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETI DATE |
|---|---|---|---|---|
| N 000 | Initial Comments<br><br>A licensure survey and investigation of complaints #40954 and #41172 were completed from 4/24/17 through 4/26/17 at The Bridge at South Pittsburg. No health deficiencies were cited under Chapter 1200-08-06, Standards for Nursing Homes. | N 000 | | |

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CEO — (X6) DATE: 5/16/17